TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Bone and Joint Center

Respondent Name
Preferred Professional Insurance

MFDR Tracking Number
M4-16-1003-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $597.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier maintains that it has calculated the amount due per the attached EORs."

Response Submitted by: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2015	76881 -59, -RT, 73030 –RT, 99080 -73	$597.00	$243.43

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for medical payments and denials.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §129.5 sets out the reimbursement guidelines for work status reports.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on the findings of a review organization
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is separate reimbursement due for work status report?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services 76881 -59 –RT, 77030 –RT and 99070 -73 with claim adjustment reason code 216 – "Based on the findings of a review organization." Review of the submitted documentation finds no evidence of "findings or a review organization." 28 Texas Administrative Code §133.240(p) and (q) states,

   For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title. Additionally, all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

   When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

The Division found insufficient evidence to support the carrier met the requirements of Rule 134.240(p) and (q). Therefore, the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (c) states,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   The maximum allowable reimbursement for the services in dispute will be calculated as follows:

Date of Service	Submitted Code	Amount Billed	Allowable	MAR (DWC Conversion Factor / Medicare Conversion Factor) x Participating Amount = TX Fee MAR
March 31, 2015	76881 -59, RT	$475.00	$116.91	56.2 / 35.935 x $116.91 = $182.84
March 31, 2015	73030 -RT	$97.00	$29.15	56.2 / 35.935 x $29.15 = $45.59
			TOTAL	$228.43

3. 28 Texas Administrative Code §129.5 (i) states, "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section

or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15." Pursuant to the above the $15.00 is recommended.

4. The total allowable for the services in dispute is $243.43. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $243.43.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $243.43 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		January , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.